

SUCCESSFUL CORRECTION OF ACUTE COMPLETE INVERSION OF UTERUS 24 HOURS AFTER DELIVERY

Pages with reference to book, From 321 To 322

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INTRODUCTION

Acute inversion of the uterus is rare, the incidence being 1 in 23000¹. If not detected and treated immediately, it may prove fatal^{2,3}. Instant replacement within a few seconds of its occurrence without any anaesthesia, except if already being used for conduct of the delivery, is desired to prevent the patient going into shock⁴. The longer the treatment is deferred, the more difficult it becomes to correct the inversion because of the tightening of the cervical ring. If the inversion cannot be corrected by vaginal manipulation, surgical intervention becomes imperative. Successful replacement 24 hours after delivery is rarely recorded. In the case reported here, the patient presented, after a lapse of 24 hours and manual replacement was performed easily under anaesthesia.

CASE REPORT

A 30 years old (grand multipara) Gravida 8 Para 8, 6 alive, two infant deaths, with history of home delivery 24 hours back was admitted as an emergency with acute complete inversion of uterus. Patient had all previous home deliveries conducted by traditional birth attendant without any obstetric complication during pregnancies, labour and deliveries. Delivery was spontaneous but the placenta was retained for over half an hour and then removed manually by the TBA. The placental removal was followed by moderate postpartum haemorrhage. The patient had felt severe lower abdominal pain and collapsed. She was taken to a local clinic where the shock was treated symptomatically. The patient continued to bleed vaginally and complained of a strong bearing down sensation. The diagnosis was missed until some hours later when a reddish mass appeared at the vulva after the patient visited the toilet. She was then transferred to the District Headquarter Hospital, Faisalabad. She was not in shock but was pyrexial (99°F). The haemoglobin was 7.9gm%. The fundus of the uterus could not be felt on abdominal palpation. A reddish turgid mass bleeding to touch was present at the vulva. Complete inversion of the uterus was confirmed on pelvic examination. The inverted mass was cleaned and reduced into the vagina. An intravenous line was secured and two unit of blood infused and other fluids were transfused. Antibiotic cover was established. The patient was then transferred to the operation theatre and manual replacement was attempted under general anaesthesia. The method described by Johnson⁵ was used. The entire hand was placed in the vagina with the tips of the fingers at the uterocervical junction and the fundus of the uterus in the palm of the hand. The uterus was lifted up to make the ligaments tense. Pressure was then exerted first to widen the cervical ring and then to push the fundus through it. The uterus was successfully replaced with slight haemorrhage during the 322 procedure. Postoperative recovery was uneventful. She was transfused 2 more units of blood to correct the anaemia. She was discharged home on the fifth postoperative day in a satisfactory condition.

DISCUSSION

Of the various causes of the acute inversion of the uterus, inexperience of the personnel performing the delivery appears to be an important factor⁶. If an untrained person inverts the uterus treatment is also delayed, thus increasing the mortality rate appreciably. Acute inversion of the uterus can be replaced

either by manipulation or by hydrostatic pressure as described by O'Sullivan⁷. Both these methods are perhaps equally effective in replacing the inversion. Ian Donald described a case of acute inversion where replacement was attempted 4 hours after the accident. Manual replacement failed in that case but hydraulic pressure was successful⁵. The efficiency of both methods decreases with lapse of time because closure and tightening of the cervical ring causes the prolapsed fundus to become oedematous. In the case reported here manual replacement was accomplished 24 hours after delivery. It is suggested that in cases of acute inversion of the uterus where treatment is delayed an attempt at manual replacement must be made before resorting to surgical intervention.

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